State of Arizona COBRA Enrollment/Change Form 2004/2005

☐ New Enrollee ☐ Qualified Life Event ☐ Address Change ☐ Open Enrollment

AGENCY NAME/PROCESS LEVEL	DATE ENROLLEE NOTIFIED	COBRA EFFECTIVE DATE

Duration of COBRA Coverage

☐ 18 Months ☐ 29 Months (only if disabled at the time of COBRA election) ☐ 36 Months

Do Not Write Above This Line – For Agency Use Only

ENROLLEE IDENTIFICATION

ENROLLEE LAST NAME, FIRST NAME, M.I.	SOCIAL SECURITY NUMBER or EIN	☐ MALE ☐ FEMALE	☐ MARRIED ☐ SINGLE
STREET ADDRESS	COUNTY OF RESIDENCE	DATE OF BIRTH	
CITY, STATE, ZIP CODE	WORK PHONE NUMBER ( )	HOME PHONE NUMBER ( )	
EMPLOYEE LAST NAME, FIRST NAME, M.I.	EMPLOYEE EIN or SSN	SPOUSE'S EMPLOYER	

MEDICAL PLAN SELECTION – Check appropriate box

☐ I decline Medical Coverage	MONTHLY PREMIUM SINGLE COVERAGE	MONTHLY PREMIUM FAMILY COVERAGE
Central Region: Maricopa, Gila, and Pinal Counties		
RAN+AMN EPO	$343.74	$859.86
Schaller Anderson Healthcare (SA) EPO	$343.74	$859.86
UnitedHealthcare (UHC) EPO	$353.94	$870.06
Arizona Foundation (AZF) PPO	$570.18	$1,397.40
UnitedHealthcare (UHC) PPO	$580.38	$1,407.60
Southern Region: Pima and Santa Cruz Counties		
RAN+AMN EPO	$333.54	$833.34
Schaller Anderson Healthcare (SA) EPO	$333.54	$833.34
UnitedHealthcare (UHC) EPO	$343.74	$843.54
Arizona Foundation (AZF) PPO	$526.32	$1,273.98
UnitedHealthcare (UHC) PPO	$536.52	$1,284.18
Northern Region: Yavapai, Coconino, Navajo and Apache Counties		
RAN+AMN EPO	$453.90	$1,135.26
Arizona Foundation (AZF) PPO	$594.66	$1,487.16
Southeastern Region: Graham, Greenlee and Cochise Counties		
RAN+AMN EPO	$453.90	$1,135.26
Arizona Foundation (AZF) PPO	$594.66	$1,487.16
Western Region: Mohave, La Paz and Yuma Counties		
RAN+AMN EPO	$453.90	$1,135.26
Arizona Foundation (AZF) PPO	$594.66	$1,487.16
Out-of-State		
Beech Street PPO	$594.66	$1,487.16
NAU Only - Blue Cross/Blue Shield		
BCBSAZ PPO	$454.04	$1,166.51

DENTAL PLAN SELECTION – Check appropriate box

☐ I decline Dental Coverage	MONTHLY PREMIUM SINGLE COVERAGE	MONTHLY PREMIUM FAMILY COVERAGE
Delta Dental Indemnity/PPO (In Arizona and Out-of-state)	$28.05	$91.19
MetLife Dental Indemnity/PPO (In Arizona and Out-of-state)	$28.05	$87.68
Employers Dental Service Prepaid Plan (In-state-only)	$9.91	$28.78
Fortis Benefits Prepaid Plan (In-state-only)	$11.08	$30.11

VISION PLAN SELECTION – Check appropriate box

☐ I decline Vision Coverage ☐ Avesis Single Coverage $6.47 ☐ Avesis Family Coverage $17.52

FLEXIBLE SPENDING ACCOUNT – Check appropriate box(es)

☐ I decline Flexible Spending	☐ I am electing to maintain Medical Reimbursement	Monthly Amount $
	☐ I am electing to maintain Dependent Care Reimbursement	Monthly Amount $

DEPENDENTS (Must Be Listed For Family Coverage)

LAST NAME, FIRST NAME, M.I.	RELATIONSHIP TO APPLICANT S=Spouse, C=Child, G=Guardian, P=Placed for adoption, T=Stepchild	BIRTHDATE (MM/DD/YY)	SOCIAL SECURITY NUMBER	MALE OR FEMALE M or F	FULL TIME STUDENT Y or N	MEDICAL PCP AND/OR DENTIST ID NUMBER	DISABLED Y or N
02 Spouse							
03							
04							
05							
06							
07							

ENROLLEE AUTHORIZATION AND SIGNATURE

I hereby certify under penalty of perjury that the information provided in this application for employee benefits, including address and spouse/dependent information is true and correct. I further acknowledge that I am aware that providing false information may subject me to a denial of employee benefits, disciplinary action, and potential prosecution pursuant to ARS Sections 13-2310, 13-2311, 13-2702, and other applicable provisions of the law.

Signature: _____ Date: _____

Return form to: ADOA Benefits Office, 100 N. 15th Ave., Suite 103, Phoenix, AZ 85007